PSYCHOLOGY CASE RECORD

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By
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Most of all, I would like to thank The Almighty God for all His blessings.

CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. Srinivasa Sivaram Kishore D** during the year 2014-2016. I also certify that this record is an independent work done by the candidate under my supervision.

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CASE RECORD 1: Personality Assessment

Name	: Mrs RS
Age	: 29 years
Sex	: Female
Marital status	: Married
Religion	: Hindu
Language	: Hindi
Education	: B.A (Hindi)
Occupation	: Housewife
Socio-economic status	: Middle
Residence	: Semi Urban
Informant	: Self and her Husband

Presenting complaints

Fainting spells	- six years duration
Excessive worry	- six years duration

History of presenting illness

. Name	: Mrs RS
Age	: 29 years
Sex	: Female
Marital status	: Married
Religion	: Hindu
Language	: Hindi
Education	: B.A (Hindi)
Occupation	: Housewife
Socio-economic status	: Middle
Residence	: Semi Urban
Informant	: Self and her Husband

Presenting complaints

Fainting spells	- six years duration
Excessive worry	- six years duration

History of presenting illness

Mrs RS was reportedly well till six years back when she developed episodes of falls initially characterised by loss of consciousness for a few seconds. There have been multiple such episodes since. The episodes occurred at different situations and during different times of the

day and its duration ranged from about five minutes to more than half an hour a times. These episodes have never been associated with aura, post episode confusion, urinary incontinence or injuries due to fall. The onset of these episodes was following the birth of her child and when she was required to go to her in laws' home. There is history of interpersonal issues between herself and her in-laws as well as with her husband initially. Although she describes her husband to be supportive, she feels that he is very discouraging and is over protective. She feels that he restricts her exposure to the society and that she feels less empowered in his presence.

Since April 2015, there has been a worsening of her episodes of loss of consciousness in terms of the frequency and intensity. Secondary to these episodes, there is history of low mood, decreased sleep, and decreased interest in activities, anxiety about her future and her health and indecisiveness in her decision making. Her appetite remained normal but she had difficulty in performing her daily chores.

There was no history suggestive of organicity

There was no history suggestive of any substance use.

There was no history suggestive of first rank symptoms.

There was no history of depressive syndrome or mania or hypomania.

There was no history of phobia or panic attacks.

Treatment history

She had been evaluated at multiple psychiatric centres and has been on various anti-depressants as well as anti-epileptics. She had also undergone evaluation in the Department of neurology and was diagnosed with cardio neuro syncope. An EEG done revealed no abnormality.

Family history

She is the eldest and has two brothers. Her younger brother is 25 years old and is an engineer while her youngest brother is 23 years old and is unemployed. Her father is a retired government service employee and her mother is a homemaker. There is no family history of any neuropsychiatric morbidity.

Developmental history

The antenatal period was supervised and uneventful. Her delivery was full term normal vaginal with no birth asphyxia or neonatal seizure. Her postnatal period was uneventful. The developmental milestones were reported to be normal.

Educational history

She has completed her Bachelor's degree in Hindi.

Sexual history

She has female gender identity and heterosexual orientation. She denied any high risk sexual behaviour. She denied any sexual dysfunction.

Marital history

She is married for eight years to Mr. SK who is a thirty six year old assistant accountant. They have a seven year old son.

Premorbid personality

She was described to be introverted and an anxious individual who was responsible, quiet and had high moral and religious standards.

Physical examination

Her vitals were stable and her systemic examinations were within normal limits.

Mental status examination

She was moderately built, adequately nourished and well kempt. She maintained good eye contact. Rapport was established easily. There was no restlessness. Her level of activity was normal. There were no abnormal involuntary movements. She was co-operative during interview. Her speech was of normal tone, pitch, reaction time and speed. Her mood was anxious and worried with normal range and reactivity. She denied any suicidal ideas. Her form and stream of thought were normal. Her content of though reveals worries about her episodes of loss of consciousness. There was no thought broadcast or thought control or thought insertion. There were no perceptual abnormalities. There were no obsessions or compulsions. Attention and concentration could be aroused and was sustained. She had good

immediate, recent and remote memory. She was oriented to time, place and person. Her intelligence was normal and judgement was intact.

Provisional diagnosis

DISSOCIATIVE CONVULSIONS

Aim for psychometry

To identify and explore significant personality factors influencing the psychopathology

Tests administered

- IPDE ICD 10 Screening questionnaire.
- 16 Personality Factor Questionnaire
- Thematic Apperception Test
- Sacks Sentence Completion Test

Behavioural observation

During the entire period of assessment, she was cooperative. She could comprehend the instructions and paid adequate attention. She appeared well motivated. She was initially anxious but gradually became confident over sessions.

IPDE ICD 10 module screening Questionnaire

Rationale for the test

It contains 59 questions which are randomly arranged and to be answered by True or False which gives an idea about the personality traits and the possible personality disorder.

Test Findings

On this screening questionnaire she had maximum responses indicating dependent and anxious personality traits followed by some responses indicating the anankastic traits.

16 Personality Factor Questionnaire

16 PF questionnaire measures a set of 16 traits that describe and predict a person's behaviour in a variety of contexts. It aims to provide comprehensive information about an individual's whole personality, revealing potential, confirming capacity to sustain performance in a larger role and helping identify development needs. It is an empirically based tool that helps to remove the subjectivity inherent in the interview or assessment process

Rationale for the Test

Test Findings

The 16 PF indicates that she is warm hearted, caring and affectionate in her interaction with people and these qualities may also result in her becoming gullible. She tends to be emotionally responsive to others and attentive to others' needs. Her ability to abstract is less and she tends to be more concrete in her thinking process. She is also reactive to stress and tends to get easily upset and emotional. She tends to be docile and accommodating in her interactions with others. She tends to be accommodating and humble. She is conservative and traditional in her outlook and does not question how things are done. She is genuine and

forthright in her views and as a result may be very revealing of personal issues resulting in her being taken advantage of.

Thematic Apperception Test

Rationale for the test

Thematic Apperception Test is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others.

Test findings

The stories are mostly descriptive. The stories show a strong need for autonomy and independence, affiliation and succorance. There are significant conflicts observed between her desire to be independent and free and her need to shoe deference to her family. The dominant emotions are admiration, sympathy, love, as well as guilt in her desire to break free from the shackles of conservative nature of her family life. All her stories have an optimistic outcome.

Sacks Sentence Completion Test

Rationale for the test

It is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-percept

Test findings

SSCT revealed severe conflicts in family and interpersonal areas particularly in her relationship with the current support group. She has a low self-esteem and self-confidence. Her attitude towards her future is ambivalent. While she is realistic about problems that she may have to face, she is optimistic that she will be able to do so. She expresses that she is naïve and that she was been manipulated by people in the past due to it. She also expresses that she will be able to handle such situations in the future and that she will be more assertive. Her attitude towards sex is positive and that she has a satisfactory sexual life. Her attitude towards others is positive and feels that she will be very helpful but has doubts about her leadership ability.

Conclusion

Personality questionnaire and projective tests were administered. Her personality was characterized by unrealistic expectations for self, disparity between need for achievement and necessary effort and resources from within. She had inability to resolve problems, was easily affected by feeling and emotionally less stable. She had emotional insecurity, adjustment difficulties, intense emotional reactivity to trivial issues and was submissive in interpersonal situations.

Management

She was admitted in view of progressive worsening symptoms. Rapport was established with the patient and the family. Her family was allowed to ventilate and was psycho educated about the nature, course and prognosis of her illness with the dissociative model. Family dynamics, structure and communication patterns were explored and husband was made aware and empowered. Dissociative model was given gradually to the patient and assertiveness,

problem solving and relaxation techniques were taught. The implications of stressful social situation were discussed. Towards the discharge the dissociative episodes were markedly reduced in frequency and duration. She was also seen to improve in the Occupational Therapy.

CASE RECORD 2: Intelligence Assessment

Name	: Mr PK
Age	: 20 years
Sex	: Male
Marital status	: Unmarried
Religion	: Hindu
Language	: Hindi
Education	: Standard X
Occupation	: Helper in a shop
Socio-economic status	: Middle
Residence	: Urban
Informant	: Father
Reliability	: Good

Presenting complaints

Anger Outbursts	- since childhood
Disobedience and poor academic performance	- since childhood

History of presenting complaints

Mr PK was brought by his father with problems of inadequacy in the work , adamant behaviour , frequent anger outbursts and other behavioural problems of lying, throwing things at home. These problems were present since childhood and gradually increased in frequency and intensity over the last two years. He is also found to pick fights with strangers. His demanding and oppositional behaviour were increasing causing significant concerns to his parents and they were unable to handle his behaviour. He was independent in his self-care activities and was able to do simple domestic chores such as making minor purchases from shops. His biological functions were normal.

There was no history suggestive of any organicity, substance use, mood disorder, psychosis, anxiety disorder, obsessive compulsive disorder, pervasive developmental disorder or conduct disorder.

Past history

There was no significant past medical history

Family history

There is family history of tobacco use in his paternal grandfather. There is no family history of any mental retardation, conduct disorder or oppositional defiant disorder.

Birth and development history

Prenatal: It was a planned pregnancy with unsupervised antenatal period. However, it was uneventful.

Perinatal: He was a born of a full term normal delivery at home. There was no history of any birth asphyxia or neonatal jaundice.

Postnatal: Both his language and motor developmental milestones were delayed

Emotional development and temperament

He was described to be a difficult child – adamant, demanding and seeking immediate gratification of his needs. He would act out behaviourally if his demands were not met. He did not engage in any self-injurious behaviour.

School history

He has completed his 10^{th} standard, however, reportedly though illegal means. His academic performance was below average.

Physical examination

All his vital signs and respiratory and gastro intestinal systemic examinations were within normal limits. There was a murmur in the mitral area and secondary sexual characters were not noted.

Mental status examination

He was thinly built and adequately nourished. He was well kempt and made poor eye contact. He occasionally smiled to himself. He was alert and lucid with no abnormal motor movements. He was cooperative but playful during the interview. There were odd and frequent changes in his posture. His speech was childish with normal reaction and comprehension. He was euthymic with normal range and reactivity of affect. There were no abnormalities in his form and stream of thought. He denied delusions and hallucinations. He was oriented to time, place and person. His memory was intact. His intelligence was below average and his insight was poor.

Provisional diagnosis

MILD INTELLECTUAL DISABILITY

Aims of psychological testing

As history was suggestive of poor scholastic performance and mental status examination revealed impairment in tests of abstraction and general knowledge, IQ assessment was imperative.

Test administered

Binet-Kamat Test of general mental abilities

Rationale for the tests

BKT was used to assess his intelligence as it is a standardised intelligence test for Indian population and assesses both verbal and nonverbal aspects of intelligence.

Behavioural observations

Mr PK was co-operative and willing for the tests. He maintained good eye contact. He was able to comprehend instructions. He was attentive but became a little fatigued towards the later part of the assessment. He had to be prompted to give the answers. No hyperactivity, performance or anticipatory anxiety was observed.

Test findings

Binet- Kamat Test

On BKT, the basal age attained was 7 years, terminal age was 19 years and the mental age was 11 years and 8 months with the corresponding IQ being 71, indicating borderline intelligence. Significant scatter is seen with the patient doing well on items measuring numerical reasoning, language and social intelligence while his performance on items measuring memory and conceptual thinking was poor.

Impression

The intelligence test found his intelligence to be borderline intelligence.

Management

1. The father was educated about the diagnosis and its implications. He was allowed to ventilate and support was provided. The doubts were clarified.
2. The father was taught about Behavioural management techniques and differentially rewarding skill behaviour and problem behaviour.

3. The need for scaling down excessive expectations in view of borderline intellectual functioning was discussed with parents. It was discussed to differentially reward Mr PK for his wanted behaviour rather than on concentrating on outcome. The possibility of searching vocational training as an option too was discussed.

CASE RECORD 3: Diagnostic Clarification

Name	: Ms M
Age	: 33 years
Sex	: Female
Marital status	: Unmarried
Religion	: Hindu
Language	: Tamil/English
Education	: BBM
Occupation	: Currently Unemployed
Socio-economic status	: Middle
Residence	: Urban
Informant	: Self and her parents

Presenting complaints

Weakness - one year duration

Difficulty in doing her activities of daily living – one year duration

Vague pain and discomfort - one year duration

Feeling low – one year duration

History of presenting illness

Ms M was brought by her parents with chronic complaints of 1year duration consisting of Weakness and easy fatigability to start with then progressing to Vague pain and discomfort which was generalized and associated with difficulty in doing her activities of daily living

with impaired socio-occupational function, which were treated at Coimbatore and there was no improvement. The symptoms worsened since 2 months expressing despair and distress.

There was no history suggestive of head injury or seizures.

There was no history suggestive of substance misuse.

There was no history suggestive of first rank symptoms.

There was no history of mania or hypomania.

There was no history of anxiety, phobias or panic attacks.

There was no history suggestive of obsessive-compulsive behaviour.

She was admitted for diagnostic clarification and management of her symptoms. A working diagnosis of Undifferentiated Somatoform Disorder was made.

Treatment history

She was treated with various vitamin supplements at Coimbatore and was evaluated in CMC, after various investigations was sent to Mental Health Centre suspecting a functional cause.

Family history

There is family history of no neuropsychiatric morbidity. Family environment was restrictive because of a conservative Hindu family .

Developmental history

The antenatal period was supervised and uneventful. Delivery was full term normal vaginal; with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. The developmental milestones were reported to be normal.

Educational and Occupational history

She had completed her Bachelors of Business Management (BBM) and worked for a period of nine months in a private bank. She was also trained in Carnatic Classical Music.

Sexual development

She had female gender identity and heterosexual orientation. She denied any high risk sexual behaviour . She had regular menstrual cycles.

Marital history

She was unmarried.

Premorbid personality

She had good social interactions. She was reportedly responsible towards work and studies, had high moral standards and was religious. She was said to be an individual who worries on trivial issues and is dependent on her parents and brother for the solution of her problems.

Physical examination

Her vitals were stable. Systemic examinations were within normal limits.

Mental status examination

She was moderately built and nourished. She was well kempt with good eye contact. Higher mental functions and speech were normal. She denied any Delusions or Hallucinations. She had poor insight and her personal and social judgment were impaired.

Provisional diagnosis with a differential diagnosis

UNDIFFERENTIATED SOMATOFORM DISORDER

SEVERE DEPRESSION WITHOUT PSYCHOSIS WITH SOMATIC SYMPTOMS

Rationale for psychometry

Clinically, the diagnosis was suggestive of somatoform disorder, but we wanted to explore the psychopathology and thereby also seek confirmation through psychometry.

Tests administered

1. Thematic Apperception Test
2. Sacks Sentence Completion Test
3. IPDE ICD 10 Screening questionnaire.

Behavioural observation

During the entire exercise, she was cooperative. She could comprehend the instructions and paid adequate attention. She was complaining of pain intermittently but was motivated .

Rationale and Findings

Thematic Apperception Test is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to Ambiguous test materials. It elicits information about a person's view of the world and his Attitudes toward the self and others.

Test findings

The stories are mostly descriptive. Needs motivated by desire for power are achievement, emotional and physical aggression, construction. Needs motivated by affection , admiration , sympathy , love are nurturance and sex. Other needs are blame avoidance. Inner states are conflict, emotional change. Presses descriptive are loss, rejection, emotional aggression. Stories are with positive endings.

Sacks Sentence Completion Test is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Test findings

SSCT revealed severe conflicts in family and interpersonal areas particularly in her relationship with her father but good relation with the mother. Moderate conflict in self area responses were primarily from the influences from within .Her thinking is predominantly mature, realistic and adequate and has responsibility towards her interests and needs of others. She also revealed conflicts related to low self esteem and ambivalence about the future.

IPDE ICD 10 module screening Questionnaire contains 59 Questions which are randomly arranged and to be answered by True or False which gives an idea about the personality traits and the possible personality disorder.

Test Findings

On this screening questionnaire she had maximum responses indicating impulsive traits, followed by some responses indicating the anxious traits and the dependent personality traits. She also showed some indication of some traits of histrionic and borderline type personality disorders. She had a mixed presentation with the personality traits from various subtypes.

Conclusion

The tests revealed her tendency to be avoidant towards the environment. She was prone to exhibit maladaptive behaviour under stressful situations. The environment was perceived as insecure. Poor interpersonal relations can be due to both the cause and the effect of her psychopathology. The test results also point towards her significant anxiety and depressive psychopathology. Psychometric analysis pointed out the low mood component of the illness. and a diagnosis of severe depression without psychosis , with somatic symptoms needs to be considered and might need rating on Hamilton Depressive Rating Scale.

Management

Psychometrically to test on Hamilton Depressive Rating Scale to quantify the pathology and start on an Appropriate Antidepressant and observe for response.

Non-pharmacologically, rapport was established with the patient and family. Her family was allowed to ventilate and was psycho educated about the nature of her illness and need for long term treatment and regular follow ups.

CASE RECORD 4: Diagnostic Clarification

Name	: Mr. TK
Age	: 31 years
Sex	: Male
Marital status	: Unmarried
Religion	: Hindu
Language	: Hindi
Education	: MBA
Occupation	: Currently unemployed
Socio-economic status	: Middle
Residence	: Urban
Informant	: Mr TK and his mother

Presenting complaints

Feeling low and weak since two years

Irritable and abusive	- two year duration
Impaired activities of daily living	- two year duration

History of presenting illness

Mr TK presented with two years duration of low mood with excessive thinking and anger outbursts with socio-occupational dysfunction and normal biological functions. Due to these symptoms, he had changed jobs multiple times in the past five years claiming the reason that his colleagues are providing him a healthy work atmosphere. He also reports that his parents are not supportive in his difficult situations. He also has a history of two failed relationships because of the disapproval of the marriage by the family. From the past one year he reports to have worsening of his symptoms and excessive unprovoked anger and irritability towards the family members. Mr TK was said to be a person who does not trust others easily and is very particular about work being done in his style and is not flexible and agreeable to his family members and colleagues. His mother reports him to be very much preoccupied with fine details at the workplace and at home and as a result said to have frequent troubled relationship with the colleagues. His excessive scrupulousness sometimes led to decreased productivity and also to the extent of escape from the work. He tends to insist that others come to his terms and reluctance to let others do work in their style. If any of his needs are unmet he is said to be in a pervasive state of apprehension. The symptoms were treated outside and developed drug induced extrapyramidal symptoms for which he was treated in neurology.

There was no history suggestive of organicity or seizures.

There was no history of substance use.

There was no history of any abnormal perception.

There was no history of or mania or hypomania.

There was no history of phobia or panic attacks.

Treatment history

He was treated with multiple antipsychotics and developed drug induced parkinsonism for which he was treated in neurology. Fluvoxamine was used up to 100 mg per day.

Family history

He has one elder sister and one younger brother. There is family history of epilepsy in his paternal uncle.

Developmental history

The antenatal period was supervised and uneventful. His birth was full term normal vaginal delivery with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. The developmental milestones were reported to be normal.

Educational history

He finished his Masters in Business Administration (MBA) in Hotel Management.

Sexual development

He had male gender identity and heterosexual orientation. There was masturbatory guilt. He denied any high risk sexual behaviour.

Marital history

He was unmarried

Premorbid personality

He had disturbed social relations. He was described as being sensitive, emotional and impulsive individual and failed intimate relationships. He had disturbed relation with the parents and also with the colleagues at the workplace.

Physical examination

His vitals were stable. Systemic examinations were within normal limits.

Mental status examination

He was a well-built individual, who maintained good eye contact and rapport was difficult to establish. There are no abnormal motor movements. There was no restlessness. His level of activity was normal. There were no abnormal involuntary movements. He was co-operative during interview. His speech was of normal tone, pitch, reaction time and speed. His mood was anxious and worried with normal range and reactivity. He denied any suicidal ideas. His form and stream of thought were normal. He denied delusions and depressive cognitions. He expressed distress that his parents were no understanding of his problems. There was no thought broadcast or thought control or thought insertion. There were no perceptual abnormalities. There were no obsessions or compulsions. Attention and concentration could be aroused and was sustained. His immediate, recent and remote memory were intact. He was oriented to time, place and person. His intelligence was normal and his social and personal judgement was impaired.

Provisional diagnosis

DYSTHYMIA

Aim for psychometry

To clarify symptomatology , psychopathology, personality traits and diagnosis

Tests administered

1. Rorschach test
2. Thematic Apperception Test
3. IPDE ICD-10 Module Screening Questionnaire.
4. Sacks Sentence Completion Test

Behavioural observation

During the entire exercise, he was cooperative. He could comprehend the instructions and paid adequate attention. He appeared well motivated.

Rationale and Findings

Rorschach Ink Blot Test provides an understanding of structure of the personality, affectional needs and ego strength. It also indicates degree of psychopathology.

Test findings

In the Rorschach protocol he has given 37 responses indicating average productivity with delayed mentation. The protocol indicates a tendency for immediate gratification of needs rather than long range goals. His inner conflicts are too strong and interfere in his day to day functioning and his ability to handle problems. It indicates denial and repression of underdeveloped need for affection which is again suggestive of adjustment difficulties. There is a lack of personal involvement in his interpersonal relationships with it being a threat to the overall stability of his personality. He tends to be stimulated by the environment and reacts to it emotionally. He tends to show less interest in being organized but has the capacity to do so. He tends to see things in an unusual way often leading to poor communication with other people. There is an absence of overcritical attitude. There is an orderly succession indicative of intellectual efficiency. Content analysis indicates variation in content suggestive good intellectual capacity. Anatomical responses indicate a tendency to be preoccupied with his own body and its functions. There are adequate numbers of popular responses indicating adequate ties with reality.

Thematic Apperception Test is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others.

Test findings

On the TAT protocol, most of the stories were well structured. The recurrent themes were that of the hero facing difficulties in life and then succumbing to the pressure. Mostly

male heroes have been identified whose prominent needs were need for achievement and approval of the parents (especially of father). The environment in most of the stories has been perceived as difficult and threatening. The significant conflicts that surfaced were acceptance versus rejection. The main anxieties were that of failure to achieve and of not being accepted by father. The main defences used were projection and reaction formation. Superego structure was found to be adequate. Overall in the TAT stories, the integration of ego was found to be inadequate. However the outcome in most stories was unrealistic and negative.

IPDE ICD 10 module screening Questionnaire contains 59 questions which are randomly arranged and to be answered by True or False which gives an idea about the personality traits and the possible personality disorder.

Test Findings

On this screening questionnaire he had maximum responses indicating impulsive traits, followed by some responses indicating the anxious traits and the dependent personality traits. He also showed some indication of some traits of anankastic personality disorder. He had a mixed presentation with the personality traits from various subtypes.

Sacks Sentence Completion Test is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Test findings

SSCT revealed difficulties in interpersonal areas particularly in the relationship with the father. Most of the responses were short and concrete. He also revealed conflicts related to low self esteem and ambivalence about the future.

Conclusion

The tests revealed his personality traits viz. sensitivity to stressors. He was prone to exhibit maladaptive behaviour under stressful situation. The environment was perceived threatening and insecure. Poor interpersonal relations can be due to both the cause and the effect of his psychopathology. The test results also point towards a depressive psychopathology. A current working diagnosis of Dysthymia was concluded.

Management

He was admitted in view of marked self care deterioration and unmanageability at home. He was started on Tab. Clomipramine at low doses. Behavioural strategies and activities of daily living scheduling was also employed. Non-pharmacologically, rapport was established with the patient. His family was allowed to ventilate and was psycho educated about the nature of his illness, course, prognosis and need for long term treatment and regular follow up. He was seen to minimally improve in Occupational Therapy. At the time of discharge, he had marginal improvement in the symptoms.

CASE RECORD 5 – Neuropsychiatric assessment

Name	: Master ASM
Age	: 12 years
Sex	: Male
Marital status	: Unmarried
Religion	: Christian
Language	: Tamil
Education	: Sixth standard.
Occupation	: Student
Socio-economic status	: Middle
Residence	: Urban
Informant	: Self and his parents

Presenting complaints

Not attentive in the class - For past five years.

Increase in activity- For past five years

Impulsive behavior in class- for two years

Teasing peers and girls- For two years

History of presenting illness

Master ASM was found to be very active since he started walking. He was always on the run even on the roads without anticipating the consequences. Would indulge in playing with electrical appliances without knowing the danger and got hurt accidentally many times. He was reported to be unable to sit attentively for more than ten minutes. The complaints were predominantly from teachers that he would not concentrate in the class and would disturb fellow students. He was treated in NIMHANS initially and was assessed here. For the past three months there is worsening of his behavior in terms of impulsivity, inattentiveness , inappropriate behavior with peers and girls, accident prone in the school environment , poor copying skills , aggressive behavior towards teachers and other children

There was no history of apathy or emotional lability or sexual disinhibition.

There was no history of forgetfulness or difficulty in speech.

There was no history of apraxia or difficulty in calculation.

There was no history suggestive of psychosis or syndromal depression or mania.

There was no history of obsessions or compulsions or phobia or panic attacks.

There was no history of head injury.

There was no history of of poor eye contact, lack of socialization or repeated movements or behaviors.

His biological functions were reportedly normal. He still continued to maintain his basic and instrumental activities of daily living independently.

Treatment history

He was treated with Tab. Clonidine at NIMHANS. He was treated with Tab. Atomoxetine upto 18 mg per day and then changed to Tab Methylphenidate upto 10 mg per day in the background of poor compliance.

Family history

There is history of dysthymia in mother and no other relevant neuropsychiatric morbidity in his family.

Birth and development history

He was born to non-consanguineous union in December 2003. The antenatal period and was uneventful. The birth was at full term by normal vaginal delivery. There was no birth asphyxia. Birth weight was 3.2 Kg. He was started on breastfeeding soon after birth. The

Gross motor and fine motor milestones were normal, but there was speech delay noted in terms of kinship words being developed at two years of age but by three years of age he was able to speak age appropriately.

Educational history

He is doing his fifth standard. He was described to be average in academics. His relationship with his peers is good but there are frequent complaints from the teachers.

Sexual history

He can identify himself as a boy .

Marital history

He is unmarried.

Emotional development and temperament

He was described to be a person who is distractible and low threshold for responsiveness with frequent anger outbursts and poor tolerance

Physical examination

His vitals were stable. There was no pallor or lymphadenopathy. His cardiovascular system examination, respiratory system examination and gastrointestinal system examinations were normal.

Central nervous system

Cranial nerves – No cranial nerve palsies

Motor system

Bulk - Normal bilaterally

Tone - Normal tone bilaterally

Power - Grade 5 power bilaterally

No involuntary movements

Sensory system

Crude touch, Pain, Temperature - Normal bilaterally

Light touch, Vibration and Joint position sense - Normal bilaterally

Reflexes

Superficial abdominal reflex - Present all four quadrants

Plantar reflex - Flexor bilaterally

Deep tendon reflexes - 2+ bilaterally

Cerebellar functions	- No signs of cerebellar dysfunction
Gait	- Normal
Meningeal signs	- Absent
Skull and spine	- Normal

Mental status examination

He was moderately built and nourished, and was adequately kempt. Eye contact could be maintained. Rapport was established. There was restlessness and hyperactivity and no abnormal involuntary movements. His primary mental functions were normal. Attention could be aroused easily but was difficult to sustain. He was oriented to time, place and person. Speech was audible with no deviation.

There was no formal thought disorder. There were no depressive cognitions. There were no delusions. There were no obsessions and compulsions. He denied having any perceptual abnormalities. There were no predominant mood symptoms. He did not report of any suicidal ideation. His intelligence was average. He had poor insight into his condition. His personal, social judgment was impaired.

Provisional diagnosis

ATTENTION DEFICIT HYPERACTIVITY DISORDER.

Aims for neuropsychological testing

1. To find out the cognitive profile of Master ASM

2. To relate the findings to clinical presentation

Tests administered

Neuropsychological Battery- Flexible Battery.:

Attention and Processing speed

I) Symbol Search

II) Coding

Visuoperceptual and perceptual reasoning

III) Block Design

IV)Matrix Reasoning

V)Picture Concept

Memory

VI)Digit Span Test

VII) Letter Number Sequencing

Verbal comprehension and language

VIII)Vocabulary

IX)Comprehension

X)Similarities

Rationale

Attention and Processing speed

Symbol Search-Here the child is asked to decide if target symbol appears in a row of symbols and to mark yes/no accordingly, It evaluates the speed of processing , visuo motor quickness, concentration and persistence.

Coding-The child is asked to transcribe a digit symbol code as quickly as possible, it evaluates the visuo-motor skills, processing speed and concentration.

Visuoperceptual and perceptual reasoning

Block Design-The child is given blocks and the picture design is shown, the child is asked to put the blocks together and to construct the design as shown in the picture. It evaluates the visual abstract ability , spatial analysis and abstract visual problem solving.

Matrix Reasoning-The child is presented with a partially filled grid and selects an item that properly completes the matrix, it evaluates the fluid reasoning

Picture Concept-From each of the rows of two or three of an object, the child was asked to select an object that goes together based on the underlying concept. This measures the fluid reasoning, perceptual organization and categorization.

Memory

Digit Span Test- The child is asked to repeat the dictated series of digits (forwards and backwards) , measures the short term auditory memory and digit backward measures the working memory)

Letter Number Sequencing- The child is presented with a mixed series of number and letter and repeats them with the numbers first and then the letter, it measures the working memory.

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Verbal comprehension and language

Vocabulary The child is asked to give oral definitions of a word, it helps us to know the knowledge of the word meanings, language development and fluency.

Comprehension The Child is given oral questions of social and practical understanding, it evaluates a social comprehension and judgment.

Similarities -The child explains how two different things or concepts could be similar, it evaluates the verbal abstract reasoning, verbal categories and concepts and the abstract ability.

Findings

Attention and Processing speed

His attention and processing speed were in the average range.

Visuoperceptual and perceptual reasoning

His perceptual reasoning was in the low average range.

Memory

His working memory was on the borderline range

Verbal comprehension and language

His verbal comprehension and language was on the borderline range.

Conclusion

On this battery significant scatter is seen with the patient being reasonably good with the processing speed and average on the items with perceptual reasoning and poor on the items associated with working memory and verbal comprehension. Overall the battery shows significant neuropsychological deficits in the areas of attention, memory and processing speed.

Management

To educate the parents about the nature of ADHD , the neuropsychological deficits caused due to the ADHD and the behavioural consequences.

To educate the parents about Neuropsychological intervention and to improve the functioning of the child academically and socially.